North Carolina Department of Health and Human Services

Division of Mental Health, Developmental Disabilities and Substance Abuse Services

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Michael F. Easley, Governor

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Michael Moseley, Director

July 9, 2004

MEMORANDUM

To: Legislative Oversight Committee Members
MH/DD/SAS Commission
Consumer/Family Advisory Committee Chairs
Advocacy Organizations and Groups
North Carolina Association of County Commissioners
County Managers
County Manager Chairs
North Carolina Council of Community Programs
State Facility Directors
Area Program Directors
Area Program Board Chairs
Provider Organizations
MH/DD/SAS Professional Organizations and Groups
MH/DD/SAS Stakeholder Organizations and Groups
Other MH/DD/SAS Stakeholders

From: Mike Moseley

Re: Communication Bulletin #022
Workforce Development Plan

Attached is the Division's strategic workforce development plan. As you know, this document describes the initial and multi-year goals and strategies for implementing a statewide system of planning and responding to education and training needs in North Carolina's public mental health, developmental disabilities and substance abuse system reform. As we proceed with reform implementation, we will continue to refine the plan based on our experience.

cc: Carmen Hooker Odom
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DHHS Division Directors
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Wayne Williams
Richard Slipsky
DMH/DD/SAS Staff

The right people with the right skills in the right place at the right time.

Workforce Development Plan 2004

Implementing Reform

NC Division of Mental Health,
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And Substance Abuse
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“All aspects of North Carolina's public system of mental health, developmental disabilities and substance abuse services/ treatments/supports for people with disabilities are involved in the reform process. All are feeling its impact. By working together - consumers, families, citizens, advocates, local and state management entities and providers - we can achieve our long term goal of a reformed system that provides people with, or at risk of, mental illness, developmental disabilities and substance abuse problems and their families the necessary prevention, intervention, treatment, services and supports they need to live successfully in communities of their choice.”

- State Plan 2003: Blueprint for Change

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Division of Mental Health, Developmental Disabilities and Substance Abuse
Workforce Development Plan

I. INTRODUCTION

"In order to facilitate a process that provides the education[1] and training[2] needed to prepare providers, their staff, families and consumers and other stakeholders to reduce stigma, promote cultural proficiency and develop a competent workforce, a comprehensive training and education plan will be developed. The plan will expand upon services including case management, identification and development of resources at pre-service and in-service as well as formal professional training at all levels of the state's educational system."[3]

A. Everything is Changing

This workforce development plan describes initial goals and strategies for implementing a coordinated and inclusive statewide system of planning for and responding to education and training needs in North Carolina's public mental health, developmental disabilities and substance abuse (mh/dd/sa) system reform. This plan describes both multi-year long-term goals and strategies and the first annual set of priorities and strategies. This plan will evolve over time. Each change in the reformed system represents tremendous needs for workforce education/ and re-education/re-training. To meet established reform outcomes, training and education results require that participants have an awareness of the reform elements/principles/criteria and require that this awareness result in both capacity and capability to implement specific reform outcomes. Entities involved in the public system must be organized to support reform through training and education initiatives. We can no longer afford the fragmented education and training efforts existing now. A great deal of good work is being done across the state, but it is not coordinated at any level. This leads to inefficiencies and confusion.

Training and education are only two aspects of the many organizational and administrative issues to be addressed in the reformed system. However, they are critical as the system seeks to cope with the reality of everything changing.

This plan proposes both annual and long-range strategies as part of a coordinated system for workforce planning and development.

> ***"****At its simplest, workforce planning is about "trying to predict the future demand for different types of staff and seeking to match this with supply." A Health Service of all the Talents: Developing the NHS Workforce*

B. Workforce Planning

Workforce planning is an agency or systems' long-term human resource methods for making sure that over time the right staff are providing the right services/supports at the right time and in the right places.

Planning must answer the following questions:

- Where are we today?
- How do our customers/consumers see us?
- How do we see the system and ourselves?
- How do we see the future? What are we going to do about it?

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[1] *Education – acquiring knowledge, skills and abilities through formal education institutions to prepare for types of work or a career.*
[2] *Training – Acquiring knowledge, skills and abilities for a person's job or responsibilities, usually after taking the job or taking on the responsibilities. See Appendix A for a model training development process.*
[3] *DMH/DD/SAS Report to the Legislative Oversight Committee, 11/12/2003*

- Where are we going?
- How do we get there?

Strategic workforce planning includes: assessing current workforce capabilities, identifying future needs, analyzing gaps, developing education and training strategies to close gaps, evaluating results and modifying the system. As it is clear that the workforce will be changing greatly in the next few years, planning ahead is essential.

> "Within the next few years, the first wave of baby-boomers will be reaching retirement age. In fact, 30percent of the federal workforce will be eligible to retire in five years and an additional 20percent could seek early retirement. However, that does not mean that 50percent of the workforce will leave at once. But it does mean that agencies must start planning for the workforce of the future."[4]

There is every reason to believe that North Carolina's workforce in mental health, developmental disabilities and substance abuse services will include similar changes. In *Ensuring a 21st Century Workforce*. The NC Commission on Workforce Development noted trends for the state's workforce to become more multi-cultural and to include ever greater participation by women and by older workers. These trends will greatly impact already problematic retention and recruitment issues in our workforce as well as call for changes in how, what and when we prepare the workforce for work.

"The labor force participation of those over age 55 will have to increase by 25 percent to maintain a consistent total employment-to-population ratio from 2005 onward…." Ensuring a 21st Century Workforce

C. Workforce Development

Workforce development refers to policies and programs that help the workforce be productive and competent in their work.

Because positive outcomes for people with disabilities are the public system's bottom line, the system must provide accessible and available services/supports that reflect practices known to lead to positive outcomes. This, in turn, requires that the workforce be competent to carry out these practices; in other words, be prepared for work.
Throughout the nation, there are gaps between what is known and what is practiced. Using mental health as an example, the US Surgeon General's 1999 report on mental health discusses the fact that "…a wide variety of community-based services are of proven value for even the most severe mental illness…. Yet a gap persists in the broad introduction and application of these advances in services delivery to local communities." Among the many possible explanations for this, the report notes, "…practitioners' lack of knowledge of research results; the lag time between the reporting of research results and the translation of new knowledge into practice; and the cost of introducing innovations into health systems."

In another mental health example, one of the goals noted in The President's New Freedom Commission on Mental Health Final Report 2003, is that, "Excellent Mental Health Care Is Delivered and Research Is Accelerated." A recommendation to advance toward that goal is to "improve and expand the workforce providing evidence-based mental health services and supports."

[4] Human Resource Management Council, US Office of Personnel Management - http://www.opm.gov/workforceplanning/index.htm

Clearly, sweeping organizational changes in the system and wide-ranging changes in expectations for services and supports create many immediate needs for training as well as the need to make long-term plans for educating and training the workforce in pre-service and in-service settings.

a) Identified Responsibilities

In North Carolina's public mh/dd/sa system, the State Plan identifies the Division is responsible for ensuring that LME staff are educated/trained. In turn, LMEs are responsible for ensuring the quality of services/supports provided by qualified community providers, and providers are responsible for ensuring the quality of their staff. Over time, it is important for these stakeholders to work together to develop a coordinated and collaborative system for making sure that the workforce knows what it needs to know and can do what it needs to do in the service and support of consumers and families.

Within the Division, the Communications and Training Team is assigned responsibility for issues related to workforce development. As such, the Team is responsible for:

- Developing a comprehensive training plan for advancing Division members' competencies in coordination with Human Resources.
- Developing training opportunities necessary for carrying out reform efforts.
- Serving as the liaison to universities, community colleges and Area Health Education Centers AHECs to facilitate training for the State Plan.
- Developing strategies to address workforce issues.

Key training partners are LMEs, through their association, the NC Council of Community Programs (NC Council), Area Health Education Centers (AHECs), universities and colleges, service providers through their associations and contractors and other state agencies.

b) Focus Areas

There are several key areas of focus in the reformed system that will drive workforce development plans. They include:

- **Person-Centeredness** – Person-centeredness refers to a set of values and attitudes that requires putting the person with disabilities in charge of what happens in his/her life. These concepts form the underpinning of the reformed system.
- **Quality management** – This refers to a continuous process that identifies problems in management and delivery of services and supports, examines solutions to those problems, and regularly monitors the solutions for improvement. Workforce members must know their part in collecting relevant data and analyzing it to figure out what improvements need to be made. Understanding and implementing quality improvement methods into business processes is required.
- **Cultural competence** – This refers to the ability of people to be conscious of how cultural and ethnic backgrounds affect peoples' values, attitudes and behaviors. This is a basic element required in services/supports processes.
- **Evidence-based or best practices** - These are methods and behaviors that are proven to result in positive outcomes for people with disabilities. Since the state, in the reformed system, will only support these and other best practices, the service and support workforce must be competent in these methods.
- **NC Administrative Rules** – The rules contain training requirements that must be met by the system. (See Appendix D)

c) Guiding Principles

1. Workforce development efforts shall help answer, in an affirmative way, the ultimate question about reform outcomes, namely "... have we positively contributed to the lives of people with disabilities and their families?"

2. An integrated workforce development system requires ongoing and systematic communication and collaboration among education and training providers and the mh/dd/sas system.

3. Training/education products shall have measurable outcomes in workforce competence, be consistent, accessible throughout the state, cost-effective and linked to best practices. Wherever applicable, local capacity development will occur.

4. Training and education programs will be developed by people with expertise following accepted professional standards. (See Appendix A for steps in training development.)

5. Education/training expenses are necessary costs for achieving reform.

d) Expected Outcomes

1. The workforce understands and can articulate the reform outcomes; can define who will get services/supports as well as impact/options for those who will not qualify for services; can carry out evidence-based or best practices; can identify expectations and outcomes for which they are accountable.

2. The workforce understands and can explain/define the elements of person centeredness, quality management and cultural awareness.

3. The workforce has the knowledge, skills and abilities (KSAs[5] or competencies[6]) deemed necessary to achieve outcomes required by the system.

4. Individual training plans are consistent with the goals and direction of system reform.

II. LONG-RANGE PLANNING: A STATEWIDE FRAMEWORK FOR WORKFORCE DEVELOPMENT

A. State Network for Workforce Development

A statewide network of system-level education and training entities is one of the three elements proposed to implement a statewide framework for workforce planning and development. This network will work collaboratively to provide long-term policy and planning advice to the state regarding a strategic and coordinated statewide system for workforce development. Because there are no other workforce planning initiatives currently underway for the public mh/dd/sas system, this network will perform necessary workforce planning functions as well as workforce development. The activities of this network will be key to implementing system reform.

The network will determine ways for appropriate data to be gathered and decisions made about long-term personnel needs in the state system. From that information, the network will begin to

[5] *Knowledge – An organized body of factual or procedural information necessary to function in a position.*
Skills – A developed set of practices to apply to a specific function or set of functions.
Ability – Application of knowledge and skills to achieve desired outcomes.
[6] *Competencies – observable and measurable knowledge, skills and abilities that contribute to successfully performing a job*

determine gaps in workforce competencies and ways for the state's education and training entities to participate in a long-range and coordinated network for educating and training the workforce.

a) Goals

- Understanding the changes being made in the public system and projecting workforce needs.
- Working collaboratively to plan for long-term statewide pre-service (education) and in-service (training) needs in the workforce.
- Recommending Division endorsement of education and training plans/programs.
- Seeking/sharing resources – Identifying possible sources for funding, space, people and expertise to carry out needed activities.
- Making recommendations regarding possible certification of professionals, associate professionals and paraprofessionals in the public system.

b) Membership

Representatives from system or statewide-level entities to include representatives from:

- University/college system
- Department of Community Colleges
- NC Area Health Education Program
- Local networks of education and training resources (another element of a statewide framework for workforce planning and development)
- Other state agencies
- DHHS Division of Human Resources Training Section
- NC Council of Community Programs
- State Consumer and Family Advisory Committee
- The Governor's Institute on Alcohol and Substance Abuse
- DMH/DD/SAS state facilities
- Providers
- Division staff

c) Timeline

The Communications and Training Team will work to establish network membership. The first meeting will be held in October 2004.

B. Local Networks for Workforce Development

A system of local/regional networks for workforce development is the second of the three elements proposed to implement a statewide framework for workforce planning and development. Membership will consist of local/regional education and training entities. Local networks are necessary. Education and training plans can be made statewide, they are generally implemented regionally and locally. These networks will form the operational element for a coordinated system of workforce education and training.

The Division and the NC Council will work together to incorporate already-existing regional networks and relationships among education and training entities into the statewide framework. If there are no networks in a given area, they will work with area LMEs to designate one of their number to take the lead on developing such a network.

Local networks will complete needs assessments, approach local resources about implementing system initiatives and evaluate processes and outcomes. They will also participate in implementing annual and long-range training plans. To foster a flow of communication and collaboration, one person from each network will participate in the statewide network.

a) Goals

- Understanding the changes being made in the public system and working collaboratively to meet known training needs.
- Participating in the statewide network.
- Participating in The Learning Portal initiative (see below).
- Sharing resources.

b) Membership

Area representatives from:

- LMEs.
- Education/training resources in the area.
- Area Health Education Agencies AHECs.
- Training providers.
- Consumer and Family Advisory Committee (CFAC).
- State facilities.

c) Timeline

Through the NC Council, the Division will support efforts in FY 04-05 to build on existing networks, to create networks if none exists in an area and to plan strategies for enhancing these alliances among LMEs, providers and education and training partners. Completion date: five to six networks in place June 2005.

C. Learning Portal

The current system for providing education and training to the mh/dd/sas workforce is fragmented. One part of the system may not know about programs/initiatives carried out in other parts. This results in duplication, gaps, confusion and resulting economic inefficiencies. It is important that the Division support one training and education system, not a collection of systems that may or may not be linked to the whole and may or may not result in the outcomes the Division wants.

To provide a way to bring order and coordination to the education and training programs/ resources it endorses, the Division will contract for development and maintenance of a website, to be called *The Learning Portal*. This is the third element in the proposed framework for workforce development. This website will:

- Contain information about approved/endorsed education and training programs, including other online training.
- Sponsor Division online courses for access by all.
- Handle registration for courses.
- Communicate information by licensing and certification boards.

The goals for the website will be to:

1. Provide the workforce a one-stop-shop for information about and access to endorsed education and training programs.

2. Increase workforce access to training when, where and how it is needed.

3. Increase collaboration among education and training providers.

4. Decrease extraneous and duplicative programs.

a) Timeline

The Division will contract with a provider by December 2004 to design and implement the Learning Portal website, set up and implement a system for getting information from education and training entities and investigate and report on platforms for establishing online training.

D. Workforce Priorities

An important part of this process is identifying workforce priorities. While these priorities may change from year to year, currently the priorities are identified as staff providing and managing local services and supports, as well as those leading and monitoring the system and making public policy. They are, respectively, providers of services/supports LMEs and the Division.

a) Staff Providing Services and Supports

The state's service definitions and requirements of best practices describe major competency expectations for key service/support workforce members. All must be trained or re-trained in Division-endorsed methods of service and support. Pre-service education programs should prepare people to implement evidence-based practices. Key workforce members include:

Paraprofessional – (Administrative Rules 10A NCAC 28A) Within the mh/dd/sas system of care this is an individual who, with the exception of staff providing respite services or personal care services, generally has a GED or high school diploma. Other combinations of education and experience also apply.

Associate Professional – (Administrative Rules 10A NCAC 28A) Within the mh/dd/sas system of care this is generally a person with a graduate or post-graduate degree who has not accumulated required experience and must be supervised by a qualified professional.

Professionals – (Administrative Rules 10A NCAC 28A) Within the mh/dd/sas system of care, these are persons licensed/certified/registered to practice in North Carolina or someone with a Master's or Bachelor's degree with required amounts of experience.

b) Staff in LMEs - Managers of Local Systems of Services and Supports

Area/county programs are making massive modifications as they assume the role of local management entity (LME). Performance agreements outline their responsibilities and

expectations. A key expectation is that of ensuring that communities of qualified service providers are developed and maintained.

c) Staff in Division - Leading, Making Policy, Monitoring

From State Plan 2003:

> "North Carolina's Department of Health and Human Services (DHHS) is ultimately responsible for the provision of services to the citizens of North Carolina who experience the most severe forms of mental illness, developmental disabilities and/or substance abuse. The DHHS Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) is designated as the organization to oversee those services and to implement mental health reform as required by Session Law 2001-437 under the direction of the Secretary of DHHS. The Division is collaborating with other DHHS divisions as well as other departments of state government as part of the reform effort. The Legislative Oversight Committee and the Commission for Mental Health, Developmental Disabilities and Substance Abuse Services are essential in providing leadership and direction for reform."

E. Consumer/Family Participation

A vital component of the workforce development process is the involvement of consumers and families. The LMEs are required to create and support local consumer and family advisory committees (CFACs), groups made up entirely of consumers and families to advise the LME. The *State Plan* calls for the DHHS Secretary to appoint a state consumer and family advisory committee (S-CFAC) to work directly with the Division leadership to implement reform. These requirements are intended to ensure the active participation of individuals and family members affected by mental illness, developmental disabilities and/or substance abuse who can best represent the perspective and needs of those served.

In order to assure thorough involvement of consumers and families in the new system, LMEs must also "create training and information opportunities, including material development and financial and other supports, to support the education and leadership development of consumers and families." A priority of the Division is its responsibility to help educate consumers and families about the system and how they can impact the system and will look for opportunities to increase capacity for training at the local level.

F. Annual Plans

The final component of the long term workforce development framework will be the development of annual plans. At the beginning of each fiscal year, the Division will publish education and training goals, objectives and strategies for the coming year. Each annual plan must be congruent with and advance long-term approaches for workforce planning and development.

III. ANNUAL PLAN FOR WORKFORCE DEVELOPMENT FY 04-05

There is a tremendous need throughout the system to plan and/or quickly deliver training already identified as high priority in order to accomplish tasks and deliverables required in FY 04-05. The Division will sponsor and co-sponsor training through contracts with the NC Council's LME Academy and Leadership Institutes, through the NC AHEC system and through colleges and universities. Information about training will be available on the Division's website at: http://www.dhhs.state.nc.us/mhddsas/. The statewide network and the regional networks will inform future annual plans. Some issues listed have already been identified by the Division and its partners as priorities for FY 04-05.

Service Definitions – Drafts of new and modified service standards (service definitions) have been published by the Division (1/15/04) and are available on the Division's website. They define what, where, when and to whom reimbursable services may be provided. Priorities for developing training for service providers in FY04-05 will include:

1. Training for service definitions will occur in two phases:
    - Overview: The Division will sponsor workshops in FY 04-05 targeted toward LMEs and qualified community service providers.
    - More intensive:
        - Understanding community support – The Division will contract for more intensive training by the third quarter of FY 04-05. Target audiences are staff who will be providing/managing community supports.
        - Assertive community treatment teams– The service definition states, "Each ACTT team staff member must successfully participate in Division approved ACTT training. The Division-approved training will focus on developing staff competencies for delivering ACTT services according to the most recent evidenced-based practices." Events to be scheduled by the third quarter of FY 04-05.

LME organizational development needs – The North Carolina Council of Community Programs is developing a set of forums to be held throughout the year. Collectively, they are called the *LME Academy*. The Division will collaborate with the NC Council to provide training opportunities through this mechanism. Plans are underway to provide in-depth coverage of issues such as quality improvement, customer service and integrating evidence-based practices. More training will be provided as needs assessments are completed. Training will take place throughout FY 04-05.

Consumer and Family Advisory Committee Leadership Training – The Division is sponsoring training events through the NC Council for members of Consumer and Family Advisory Committees through the Council's *Leadership Institute*. Training will take place throughout FY 04-05.

Person-centeredness - The Division is contracting for a curriculum on person-centeredness, or person-centered thinking. After field testing, the Division will sponsor dissemination of the training through a train-the-trainer process. It is expected that trainers will provide training in communities on a regular basis throughout the fiscal year.

Person-centered planning - These are life planning methods (processes) of determining ends (real life outcomes) for individuals and developing means to those ends (strategies). In the reformed system, person-centered plans are central to determining how and what services and supports will be provided. Only approved training programs may be used to train system workforce members.

Several planning models are already identified in the *State Plan* as best practices. By July 2004, the Division will set up a system to review and approve other person-centered planning curricula and to provide a registry of approved programs online.

Expansion of person-centered planning models:

- ***In substance abuse treatment —*** The Division will contract for design and implementation of a training program on person-centered planning in the substance abuse system. This one-day program will be presented once each quarter. It will be

congruent with the concepts of Motivational Interviewing (MI)[7] and Motivational Enhancement Therapy (MET),[8] models of treatment seen as leading to person-centered planning in substance abuse treatment.

- ***In mental health treatment***[9] - The Division will contract for design and implementation of a training program on person-centered planning in the mental health system. This one-day program will be presented once each quarter. By December 2004, the Division will also complete a national search for emerging person-centered planning models.

- ***In child mental health treatment*** – By June 2005, the Division will incorporate person-centered planning essential elements (Noted in Communication Bulletin 15) into existing systems of care training.

Systems of care in child services – The draft plan for child mental health training in FY 04-05 is focused around the following:

- Defining and building competencies for a system of care
- Strategic planning for community education/referrals presentations
- Building and maintaining community capacity

Training will take place throughout FY 04-05, with specific dates to be determined.

Adult mental health evidence-based practices –

- The Division, through a federal Science to Service Project, is supporting development of training in adult mental health evidence-based practices from Robert Wood Johnson Foundation Toolkits. Information about these training programs in North Carolina are on the web at: http://www.ncs2s.org/

Adult mental health/substance abuse practices - The Division will contract for staff training in treatment strategies for persons with substance abuse and mental illness (co-occurring disorders), implementation to begin in the fourth quarter of FY 04-05.

Developmental disabilities – There will be an emphasis this year on providing training on crisis planning, housing, primary health and dental care, employment-related services and supports and promoting leisure and recreational participation and inclusion.

Quality improvement – As a first step toward developing a quality improvement training plan, in the fourth quarter of FY 04-05, the Division will complete a comprehensive assessment of training needs at all levels of the public system. (See Appendix A for a discussion of steps in a training process.)

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[7] *"Motivational interviewing is a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence." It is seen as a best practice in substance abuse treatment. The Division is supporting training through its substance abuse resources for ten practice improvement sites throughout North Carolina.*

[8] *"Motivational Enhancement Therapy (MET) seeks to evoke from clients their own motivation for change and to consolidate a personal decision and plan for change. The approach is largely client centered, although planned and directed." It is seen as a best practice in substance abuse treatment. The Division is supporting training through its substance abuse resources for ten practice improvement sites throughout North Carolina.*

[9] *Person-centered planning is already a best practice within services and supports for people with developmental disabilities.*

Cultural competence – In FY 03-04, the NC Department of Health and Human Services (DHHS) launched a project regarding improving cultural competence in the public system. As a first step, focus groups were organized in March 2004. By December 2004, the Division will have reviewed recommendations made by the focus groups and developed a plan for increasing cultural competence among the LMEs, providers, Division staff and stakeholders.

Conferences

The Division will support conferences required by funding agencies and the following events:

1. Rights and Empowerment Conference
2. Case Management/Community Supports Conference
3. Clinical Updates
4. Direct Care Workers Institute
5. Developmental Disabilities Best Practices

Division central office staff training - The Communications and Training Team will survey the staff through a formal needs assessment process in the first quarter of FY 04-05 to determine what training is needed to help them understand and fulfill their roles. Focus will be on leadership, policy-making and monitoring functions. In-house training will be provided in FY04-05 when approved by the Division's Executive Leadership Team.

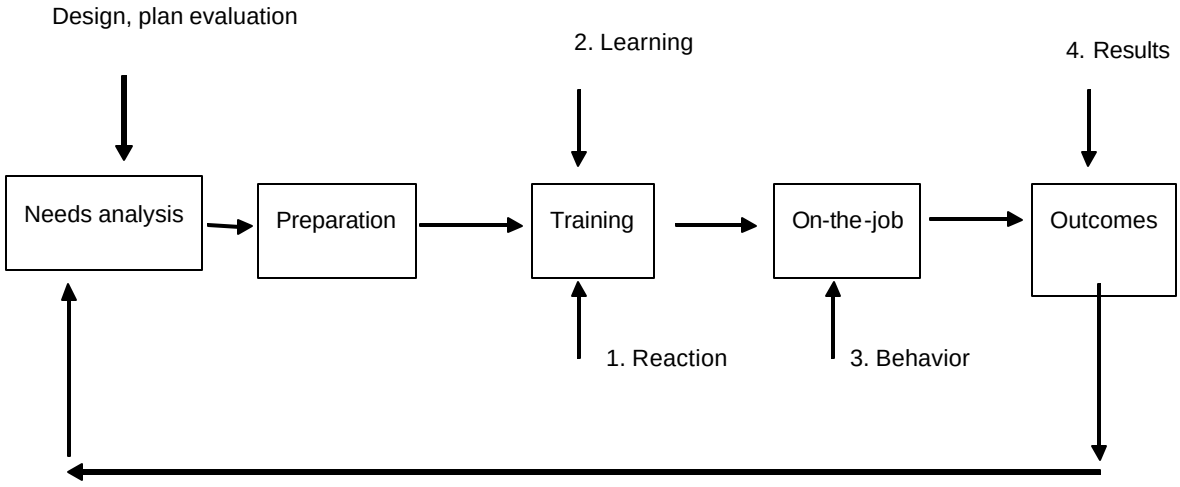
Division state facility staff training – Representatives from the Division's Communications and Training Team will meet/communicate regularly with facility staff development coordinators to address changing facility needs.

NC Interventions (NCI) - This is the Division's training program designed to prevent use of restraints and seclusion. It is required in all state facilities, and community programs may voluntarily use it. NCI is an example of the Division developing workforce capacity at the local level through voluntary participation by local programs.

The Communications and Training Team provides staff support to Instructors (approximately 400) and Instructor Trainers (over 50) and maintains information and a listing on the Division's website. The Division will continue to certify and re-certify Instructors and Instructor Trainers throughout the fiscal year as required by NC Administrative Rules.

Medication Administration Course for Unlicensed Personnel in Community Residential Facilities –Training of this type is required in the NC Administrative Rules. The Division has arranged with AHECs to provide instructor training on a regular basis to potential trainers, as the need is identified in their local areas. The Division monitors these efforts and maintains a registry of trainers who agree to be listed online.

IV. Appendix A. Training Development Process



Steps in the Training Process

The figure above describes graphically a training development process. Such a process should include:

Needs analysis

- Questions before developing training:
- What is the goal?
- What do people need to know, do?
- Who is the audience?
- What methods are going to be used to teach each audience? The best way to approach this is to think in terms of what is coming to be called blended learning methods. This means to look at a combination of potential methods for training delivery such as online, instructor led or not; on CD; as teleconferences; in face-to-face classrooms; and/or by providing written material, etc.
- What resources are available?

Preparation of the training

- Selection or development of curricula.
- Use of various modalities for delivery and respective adult learning styles.

Ongoing evaluation

This process focuses on the need for early attention to evaluation. It is an example of the idea that "if you don't know where you're going, you're not going to get there. *Getting there*, of course, means promotion of the organization's goals or strategic outcomes. The numbered items in the figure above are the four steps in a traditional model for evaluating training. They are:

- Trainee reactions - Did the trainees feel positive about the experience?
- Learning - Did the trainees learn what they were supposed to learn?
- Transfer (performance outcomes) - Did the skills, methods, attitudes learned in training transfer to the job/responsibility setting?
- Business results/performance outcomes - Were the results what was wanted? Did the results benefit the organization, meet business needs?

Outcomes

The outcomes of all training should be measured and the information used to improve the training. Numbers "3" and "4" in the diagram on page 14 are the most difficult to measure and the most valuable to the organization. Transfer of skill and attitudes learned in training to the job setting is very dependent on the attitudes and skills of supervisors and managers. They have to "buy in" to the training before it occurs and expect and support the new skills and attitudes on the job. Usually the question of benefits to the organization is resolved at the beginning of the process. That is, management determines that the training will help the organization and lends support to the effort.

V. Appendix B. Acknowledgements

Thank you to the many people who have already contributed thoughts and ideas to this training plan. They include:

Ann Remington, Consumer Empowerment Team, DMH/DD/SAS

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Judith Mann, Department of Community Colleges

Karen Blicher, Mountain AHEC

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Members of the Commission for Mental Health, Developmental Disabilities and Substance Abuse Services

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VII. Appendix D NC Administrative Rule Citations for Training

10A NCAC 27G .0202 (g) PERSONNEL REQUIREMENTS

Employee training programs shall be provided and, at a minimum, shall consist of the following:
(1) general organizational orientation;
(2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B;
(3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and
(4) training in infectious diseases and bloodborne pathogens….
(h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction.

10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS

(c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence.
(d) Competence shall be demonstrated by exhibiting core skills including:

(1) technical knowledge;
(2) cultural awareness;
(3) analytical skills;
(4) decision-making;
(5) interpersonal skills;
(6) communication skills; and
(7) clinical skills.

10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS

(d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence.
(e) Competence shall be demonstrated by exhibiting core skills including:
(1) technical knowledge;
(2) cultural awareness;
(3) analytical skills;
(4) decision-making;
(5) interpersonal skills;
(6) communication skills; and
(7) clinical skills.

10A NCAC 27G .0209 MEDICATION REQUIREMENTS

(c) Medication administration:

(3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications.

10A NCAC 28D .0209 TRAINING: EMPHASIS ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS

(a) Facilities shall implement policies and practices that emphasize the use of alternatives to seclusion, physical restraint and isolation time-out....

(d) The training shall be competency based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course....

(e) Formal refresher training shall be completed at least annually by each service provider.

(f) Content of the training that the service provider plans to use shall be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule.

(g) Staff shall demonstrate competence in the following core areas:

(1) knowledge and understanding of the people being served;
(2) recognizing and interpreting human behavior;
(3) recognizing the effect of internal and external stressors that may affect people with disabilities;
(4) strategies for building positive relationships with people with disabilities;
(5) recognizing cultural, environmental and organizational factors that may affect people with disabilities;
(6) recognizing the importance, and assisting people with disabilities in making decisions about their life;
(7) skills in assessing individual risk for escalating behavior;
(8) communication strategies for defusing and de-escalating potentially dangerous behavior; and
(9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe).

10A NCAC 28D .0209 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIMEOUT

(a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained at least annually and have demonstrated competence.

(b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers, shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated.

(c) A prerequisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for seclusion, physical restraint and isolation time-out.

(d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.

(e) Formal refresher training shall be completed by each service provider periodically (minimum annually).

(f) Content of the training that the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule.

10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIMEOUT

(a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually.

(c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions.

(d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.

10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS

(b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies....

(g) Staff shall demonstrate competence in the following core areas:

(1) knowledge and understanding of the people being served;
(2) recognizing and interpreting human behavior;
(3) recognizing the effect of internal and external stressors that may affect people with disabilities;
(4) strategies for building positive relationships with persons with disabilities;
(5) recognizing cultural, environmental and organizational factors that may affect people with disabilities;
(6) recognizing the importance of and assisting in the person's involvement in making decisions about their life;
(7) skills in assessing individual risk for escalating behavior;
(8) communication strategies for defusing and de-escalating potentially dangerous behavior; and
(9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe).

SECTION .4100 - RESIDENTIAL RECOVERY PROGRAMS FOR INDIVIDUALS WITH SUBSTANCE ABUSE DISORDERS AND THEIR CHILDREN

10A NCAC 27G .4102 STAFF

(d) Each individual identified as a residential staff member shall receive pre-service training in the following areas:

(1) confidentiality;
(2) client rights;
(3) crisis management;
(4) developmentally appropriate child behavior management;
(5) medication education and administration;
(6) symptoms of secondary complications to substance abuse or drug addiction;
(7) signs and symptoms of pre-term labor; and
(8) signs and symptoms of post-partum complications.

(e) Adequate training to support the therapeutic process shall also be provided to all residential staff in the following areas within 60 days of employment:

(1) therapeutic parenting skills;

(2) dynamics and needs of emotionally disturbed and substance abusing individuals and their children;
(3) multi-cultural and gender specific issues;
(4) issues of substance abuse and the process of recovery;
(5) HIV/AIDS;
(6) sexually transmitted diseases;
(7) drug screening;
(8) domestic violence, sexual abuse, and sexual assault;
(9) pregnancy, delivery and well child care; and
(10) infant feeding, including breast feeding.

10A NCAC 27G .4303 STAFF THERAPEUTIC COMMUNITY

(c) Each direct care staff member shall receive training in the following areas within 90 days of employment:
(1) the history, philosophy and operations of the therapeutic community;
(2) manipulative, anti-social and self-defeating behaviors;
(3) behavior modification techniques; and
(4) in programs which serve as alternatives to incarceration, training shall be received on:
(A) personality traits of offenders and criminogenic behavior; and
(B) the criminal justice system.

(d) Each direct care staff member shall receive continuing education which shall include understanding the nature of addiction, the withdrawal syndrome, symptoms of secondary complications to substance abuse or drug addiction, HIV/AIDS, sexually-transmitted diseases, and drug screening.

(e) In a facility with children and pregnant women, each direct care staff member shall receive training in:
(1) developmentally-appropriate child behavior management;
(2) signs and symptoms of pre-term labor;
(3) signs and symptoms of post-partum depression;
(4) therapeutic parenting skills;
(5) dynamics and needs of children and adults diagnosed as ADD/ADHD;
(6) domestic violence, sexual abuse and sexual assault;
(7) pregnancy, delivery and well-child care; and
(8) infant feeding, including breast feeding.

10A NCAC 29D .0402 STAFF -- THERAPEUTIC HOMES FOR CHILDREN AND ADOLESCENTS

(c) The individual identified as the therapeutic home parent shall receive training in treatment services which shall include, but not be limited to, the following:
(1) child and adolescent development;
(2) dynamics of emotionally disturbed and substance abusing youth and families;
(3) symptoms of substance abuse;
(4) needs of emotionally disturbed and substance abusing youth in residential settings;
(5) administration of medication;
(6) confidentiality;
(7) client rights; and
(8) development of the individual treatment plan.